DRUGGED DRIVING CONFERENCE

March 4-6, 2019
Law Enforcement Administrative Facility (LEAF)

DRE PROGRAM – INTRODUCTION AND HISTORY

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Distributed by:

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History and Development of the DRE Program

America: A Drug History

According to the 2005 Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health, an estimated 19.7 million Americans 12 years and older, were current (use in the month prior to the survey) illicit drug users. This number reflects 8.1% of the population aged 12 years old or older. Illicit drugs include: marijuana/ hashish, cocaine (including crack), heroin, hallucinogens, inhalants or prescription-type psychotherapeutics used non-medically. In addition, the Federal Bureau of Investigation (FBI) estimated that approximately 1.8 million people were arrested on drug abuse violations in 2005 compared to 1.5 million in 1995. Drugs, including alcohol, are an integral part of most cases involving domestic abuse, assaults, sex assaults, child abuse/neglect, theft, robbery, burglary, gangs, homicides, and driving under the influence.

Most Americans do not realize that the drug problem began, not in the 1960's, but in the middle to latter 19th century. Many medications, both over the counter and prescribed, were heavily laden with opium, laudanum, or cocaine. Typical uses for these type drugs were for children's teething, menstrual discomfort, insomnia, coughs, and general pain relief. Drugs such as cocaine were even added to some beverages such as Coca-Cola and Vin Mariani wine.

Due to concerns about the increasing use and abuse of drugs, the government responded by passing the Pure Food and Drug Act of 1906 and the Harrison Narcotic Act of 1914. Following the legislation, drug use declined considerably until the late 1920's, when an increased awareness of marijuana and heroin use brought the problem to a level of national concern.

In 1930, Harry J. Anslinger was appointed to the post of Director of the Bureau of Narcotics and a "War on Drugs" had begun. The government position on drug effects was not always supported by research. Because of some inaccurate warnings about the effects of drug use and disagreements that arose in the medical community about the benefits and risks of certain drugs, the credibility of the government and the scientific community suffered. Today we have still not overcome this legacy of skepticism and it affects the way a large segment of our society feels about drugs.

Drug use and abuse continued to increase throughout the 1960's and 70's. Unrest over the war in Vietnam, as well as ongoing societal changes, fostered a desire and climate where drug use and experimentation were considered by many to be a legitimate expression of

the need for change. In the early 1980's, a concentrated effort was made by government, law enforcement, educators, and others to deal with the drug problem by increasing public awareness and education.

Drug use declined until the early 1990's, then increased with the growing popularity of drugs such as marijuana, heroin, LSD, methamphetamine, GHB (Gamma hydroxy Butyrate) and new designer hallucinogens. As drug use increased, the numbers of individuals driving under the influence of drugs also increased. According to the 2005 Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health, in 2005, 10.5 million persons aged 12 and older reported driving under the influence of an illicit drug during the past year. Increased awareness has led to an increase in State laws prohibiting driving under the influence of drugs, and the need for better strategies to detect, apprehend, and prosecute the drug-impaired driver.

The Impaired Driving

Problem *Alcohol*

A study by the National Highway Traffic Safety Administration in 2001 showed that approximately three in every 10 Americans will be involved in an alcohol-related crash at some time in their lives. In 2006, over 17,000 Americans were killed in alcohol-related motor vehicle crashes – one almost every half hour. This horrific figure accounts for approximately 39% of all traffic related deaths in the United States.

As the public demands that more be done to detect, apprehend and prosecute impaired drivers, law enforcement and prosecutors have had to devote more resources to help achieve these ends. In all States, the legal limit for Driving Under the Influence is a BAC of .08. A few States have a two-tier system for Driving Under the Influence and Driving While Ability Impaired while others have laws that simply state that it is illegal for anyone to operate a vehicle while impaired to the slightest degree.

Law enforcement is becoming better trained and more skilled at the tasks of detection and apprehension. There are three detection phases and each involves major tasks and decisions.

Phase One-Vehicle in Motion: Law enforcement's first task is to observe the vehicle in operation. Based on this observation, law enforcement must decide whether there is reasonable cause to stop the driver. If the driver is stopped, the second task is to observe the stopping sequence.

Phase Two-Personal Contact: Once the vehicle is stopped, law enforcement will first observe and interview the driver face-to-face. Based on the observations, law enforcement must decide whether there is cause to ask the driver to step out of the vehicle for further

investigation. If the driver is asked to get out of the vehicle, the next task is to observe the driver's exit and walk.

Phase Three-Pre-arrest Screening: Once out of the vehicle, law enforcement will administer the Standardized Field Sobriety Tests (SFSTs) to the driver. Based on the driver's performance on these tests (Horizontal Gaze Nystagmus, Walk and Turn and One Leg Stand), as well as on an accumulation of all the observations and evidence obtained, law enforcement will then make a determination as to whether there is probable cause to arrest the driver for DUI.

Alcohol is a Central Nervous System Depressant. It decreases a person's ability to correctly process and act on information. Alcohol impairs the ability to perform multiple tasks simultaneously. This is known as divided attention. The ability to divide attention is crucial to operating a vehicle safely. Consider the different tasks a driver has to perform while driving. The Walk and Turn and One Leg Stand are two of the Standardized Field Sobriety Tests that require the driver to divide attention. To successfully complete these tests, the driver must be able to perform several tasks at a time, such as looking down at his feet and counting each step out loud.

The SFSTs have been validated to show, if an individual cannot successfully perform them, that their ability to operate a vehicle is impaired. The SFSTs were originally validated by scientific research conducted at the Southern California Research Institute. These tests were again validated in the 1995 Colorado study, which concluded that, "the SFSTs are valid tests; they serve as indices of the presence of alcohol at impairing levels," and in the 1998 Florida Study which showed that SFSTs were as effective for a .08 BAC. See Reference List at the conclusion of this section for citations to all validation studies.

Drugs

Driving under the influence of drugs other than alcohol is a problem in today's society. As previously discussed, drugs have become an integral part of our national fabric. National studies show that approximately 10-22% of impaired drivers have one or more drugs, other than alcohol, in their system.

A California study showed that 51% of 440 young male drivers killed in crashes had used drugs other than alcohol. A 1988 Tennessee study reported that 40% of crash-injured drivers tested positive for drugs other than alcohol, and in 1986, the Maryland Shock Trauma Center found nearly one-third of crash-injured drivers had recently used marijuana. These studies also show that many drivers are poly-drug users, that is they use more than one drug at a time.

For many years law enforcement did not have the training or the scientific support to detect drivers impaired by drugs other than alcohol. It was common to find law enforcement who arrested individuals for DUI, and when the BAC results were low, the cases were dismissed.

This started to change when the DEC (Drug Evaluation and Classification) program became a reality in the late 1970s. With the DEC program, law enforcement now has a validated method to determine if someone is under the influence of a category or categories of drugs. For our purposes the definition of a drug is, "any substance, which, when taken into the human body, can impair the ability of the person to operate a vehicle safely".

In the DRE section, you will be learning more about this program as it pertains to DUI-drug, but there are many other uses for the DRE.

Before DRE

In the 1970s, prior to the establishment of the Drug Evaluation and Classification (DEC) Program, roadside tests to determine if a person was under the influence of alcohol or drugs were not standardized. Through trial and error, law enforcement officers developed their own procedures to determine if the individual should be arrested for driving under the influence These non-standardized roadside sobriety tests frequently included variations of counting and alphabet-recitation exercises, coin pick-up tests, and assorted balance and coordination tests.

Law enforcement quickly learned that the intoxicated person had difficulty remembering and following instructions, particularly more than one at the same time. For example, law enforcement would request the driver's license and registration and as the suspect began to reach for these items, law enforcement would ask another question - the year of the car. The driver had to be reminded to produce the license and registration. Without being aware of it, law enforcement was assessing the person's ability to divide his attention, that is, to do more than one thing at the same time.

Based on the totality of the investigation – including the individual's driving, law enforcement's general observations of the person's speech, appearance, demeanor, and the person's performance on the non-standardized roadside tests – law enforcement would make an arrest or release decision. If arrested, the driver would be taken to a police station, and would be advised of his rights, and the consequences and obligations under the implied consent law. Typically, the driver would be administered an alcohol breath test. The case would then be presented to the prosecuting attorney for review and prosecution.

Prior to the development of the DEC program, law enforcement encountered significantly impaired drivers whose breath test results did not account for their level of impairment. Law enforcement had little option other than release of these drivers without any way to determine whether other drugs might be present. Few law enforcement officers were familiar with the effect of various drugs on individuals.

In some cases, a blood or urine sample disclosed the presence of drugs in a suspected impaired driver. However, it was often difficult, if not impossible, to obtain a filing of charges in court, much less a conviction. Prosecutors were hampered by law enforcement's limited abilities in articulating the basis of the opinion that the person was under the influence of drugs. A procedure was needed that law enforcement could utilize in order to be able to detect, apprehend, assess, document, and subsequently prove in a court of law that the individual was under the influence of a drug. The Drug Evaluation and Classification (DEC) Program, procedures, and DRE-trained law enforcement were the response to this recognized need.

DRE Begins

Today, the typical driving under the influence arrest begins with the law enforcement's observations of driving, followed by law enforcement's face-to-face contact with the person. The major difference between the 1970s and the present is that law enforcement now have a standardized method of assessing alcohol and drug-impairment at roadside: the Standardized Field Sobriety Tests (SFSTs).

In the United States, most law enforcement are taught the three phases of Driving Under the Influence (DUI) detection: (1) vehicle in motion, (2) personal contact, and (3) pre-arrest screening. Each of these phases requires decision making on law enforcement's part. In phase one, vehicle in motion, law enforcement's primary decision is whether to stop the vehicle. In phase two, law enforcement's primary decision is whether the driver should be instructed to exit the vehicle for further investigation. Law enforcement's primary decision in phase three is whether to arrest the person. The development, refinement, and validation of standardized procedures for phase three commenced at the same time that the need for procedures to detect the drug-impaired driver was growing.

A three-test battery was found to be the most reliable predictor of a 0.10% BAC: horizontal gaze nystagmus (HGN) test, walk and turn test, and the one-leg stand test. When these tests were administered by trained law enforcement as a battery of examinations, they could reliably determine if an individual's BAC was at or above the most common legal level at the time -0.10%.

The SFST battery includes an assessment of an individual's ability to pay attention, follow simple instructions, and divide his attention. For example, during the walk-and-turn test, the suspect is instructed to stand on a real or imaginary line with one foot in front of the other. While the suspect stands in this position, administering law enforcement gives verbal instructions while at the same time demonstrating how the test is to be performed. Often a suspect who is under the influence will "forget" to maintain the initial position, and will

either begin to perform the walking portion of the test before being told to do so, or will step out of the initial (instructional) position. During the walking or performance phase, the individual who is unable to divide his attention will frequently forget part of the instructions, such as counting out loud or touching heel to toe. With the support of the United States Department of Transportation, the battery of tests, known as the SFST, became the curriculum to train law enforcement in DUI detection.

Concurrent with the development of the SFSTs, drug abuse continued its steady increase. There was also a growing awareness by law enforcement, traffic safety researchers, and prosecutors that drug-impaired drivers were significantly contributing to traffic injuries and fatalities. As a result, traffic enforcement officers from the Los Angeles Police Department (LAPD) began to develop their own expertise on the effects of impairing drugs other than alcohol. These law enforcement officers consulted and worked with law enforcement from LAPD's Narcotics Division. They consulted with doctors, psychologists, and drug abusers to educate themselves about the effects of drugs. In time, LAPD law enforcement developed a step-by-step procedure that better enabled them to detect and document drug impaired drivers.

Without the prosecutor's willingness to prosecute the DUI-drug case, the DUI-drug case stops in the street.

1. Traffic crashes are the leading cause of deaths in the United States.
2. DUI-drugs contribute significantly to carnage on the road.

Fact: Research into drugs and driving continues to disclose an alarmingly high contribution by drugs to crashes, deaths and injuries.

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Laboratory and Field Evaluation and Curriculum Development of the DEC Program

Two Stages of validation

- Stage one: Laboratory Validation Study – Johns Hopkins University
- Stage two: Field Validation study – Los Angeles

Laboratory study Results

- DREs correctly identified 95% of drug free subjects as "unimpaired"
- DREs classified 98.7% of high-dose subjects as "impaired"
- Correctly identified the category of drugs for 91.7% of high-dose subjects
- DRES were less successful in classifying low-dose subjects

Los Angeles Field Validation Study

- **173** drivers accused of drug impairment
- Blood tests confirmed
    - **One** suspect had no drugs or alcohol
    - **10** had alcohol only
    - **37** (21%) had one drug
    - **82** (47%) had two drugs
    - **43** (25%) had three or more drugs
- Blood tests confirmed the presence of at least one "predicted" category of drugs for more than of the suspects

The Drug Recognition Expert Program was becoming institutionalized within the LAPD and within Los Angeles courts in the early 1980s. The National Highway Traffic Safety Administration (NHTSA), an agency within the U.S. Department of Transportation, began to receive requests from various sources to study the validity and reliability of the DRE procedure. In response, NHTSA, in cooperation with the National Institute on Drug Abuse, undertook a laboratory evaluation of DRE procedures in 1984 at the Johns Hopkins University. Four LAPD DREs traveled to Johns Hopkins University. An experimental protocol was designed to test the accuracy of the DREs. Each of the officers was isolated, and independently conducted an assessment of 80 volunteer drug users. In a double-blind format, each of the volunteers had received either marijuana (2 dose levels), diazepam (2 dose levels), amphetamine (2 dose levels), secobarbital (1 dose level), or a placebo.

Each DRE was allowed up to 20 minutes to complete an assessment. Each of the officers was required to determine if the volunteer was impaired and, if so, the drug category that was causing the observed impairment. In this controlled clinical study, DREs were over 90% accurate in

determining impairment, and correctly identifying the category of drug causing the impairment. The time had come to evaluate the DRE procedures in the law enforcement environment.

A hands-on approach requires participants to become active participants instead of passive participants. Hands-on instruction is learning by doing. It is the Application principle in the Cycle of Instruction. Participants in multisensory environments remember and internalize more. Hands-on learning helps eliminate the "illusion of knowing" wherein participants believe they know but later are not able to replicate it by doing. It often takes the attempt to apply the information to prove to us that we do not understand it yet.

An example of this hands-on instruction is how standardized field sobriety test are effectively taught. Police officers are first introduced to the fundamental principles and studies behind the standardized field sobriety tests protocol. The instructors then provide actual demonstration of the proper administration of each of the three tests. Next, cadets are given opportunities to apply the tests in controlled environments. The optimal next step in their instruction phase is for the cadets to implement the tests roadside with actual impaired drivers. In this way they are integrating what they have learned in the actual working environment. The more hands-on application during the instruction leads to better integration in the working environment.

In 1985, NHTSA conducted a Field Validation Study of the LAPD DRE Program. This study, which is also commonly known as the 173 Case Study, involved a much larger group of Los Angeles DREs, and involved individuals actually arrested for suspicion of driving under the influence of drugs. NHTSA contracted with a private toxicology laboratory to conduct blood analyses of samples obtained from the arrestees. The opinion of the DREs was then compared to the results of the laboratory's analyses for drugs. The results were very similar to the Johns Hopkins Study. Ninety-four percent of the time (162 suspects) a drug other than alcohol was found when the DREs said that the suspect was impaired by drugs. The drug determination was complicated by the fact that over 70% of the suspects yielded detectable levels of more than one drug. Overall, the DREs were totally correct in their judgments on 49% of the suspects, i.e., all the drugs were identified, and partially correct, i.e., they identified at least one of the drugs in an additional 38% of the cases. They were wrong on only twenty-three subjects (13%) in that the correct drug category was not identified. Only in one case was no drug or alcohol found.

To summarize the findings as reported by NHTSA:

When the DREs claimed drugs other than alcohol were present, they were almost always detected in the blood (94%);

Multiple drug use was common: 72% used two or more drugs including alcohol. 45% used three or more drugs including alcohol;

All of the drugs were identified in almost 50% of the subjects;

87% of the time, the DREs correctly identified at least one drug other than alcohol; Only 3.7% of the suspects who had used drugs had BACs equal to or greater than .10%.

It is likely that most, if not all, of the remainder would have been released to possibly drive again if the drug symptoms had not been recognized by the DREs. The overall conclusion of the two studies was: The LAPD drug recognition procedure provides trained law enforcement with the ability to accurately recognize the symptoms of many types of drugs used by drivers.

Subsequent studies of the DRE protocol and program in other jurisdictions, particularly Arizona, supported the conclusions of the NHTSA studies.

Curriculum Development and Institutionalization of the DEC Program

- Developed in Los Angeles in the 1970s as the Drug Recognition Expert (DRE) Program
- Institutionalized within LAPD and LA courts in the early 1980s
- 1987 – NHTSA assisted in the development and expansion of the program
- The International Association of Chiefs of Police (IACP) assumed oversight of the Program in 1989
- Today law enforcement agencies in 45 states have adopted the DRE Program
- There are approximately 6,500 certified DREs nationwide, including approximately 1,500 DRE instructors

In the early to mid-1980s, the LAPD periodically conducted DRE training. There was no formal curriculum or course outline. Rather, the training included presentations by experienced law enforcement, narcotics detectives, physicians, and other technical experts. The training course, which varied in length between three and seven days, included a field certification stage. During this certification stage, student DREs were required to conduct DRE evaluations on actual suspects while under the supervision of an experienced DRE.

Periodically, senior LAPD DREs would meet and decide as a group if the student was sufficiently proficient to be recognized as a DRE by the LAPD. Those that were recognized as proficient were deemed certified by the LAPD as a DRE. Out of need, standards for training and certification were slowly evolving.

In 1986, in recognition of the need to develop a formal curriculum, eighteen senior LAPD DREs were selected to develop and present the DRE curriculum. A DRE school was conducted in May of 1986 in Los Angeles utilizing this initial cadre of instructors. NHTSA and other agencies monitored this school, with the goals of standardizing the curriculum, and developing a comprehensive curricula package for administrators, instructors, and students. In 1987, NHTSA completed the development of these lesson

plans. NHTSA also conducted an instructor development school in Los Angeles to prepare DREs to present the curriculum. A successful DRE school was then held in Los Angeles using this new standardized curriculum.

The next step in the growth of the DEC Program was the selection of four States to pilot the expansion of the program outside of Los Angeles. The States of New York, Arizona, Colorado, and Virginia were selected. These States were selected because they had in place aggressive DUI enforcement programs, including the training of law enforcement in the SFST battery. Initially, law enforcement from these jurisdictions traveled to Los Angeles to receive the classroom portion of DRE training. Upon completing the classroom training, Los Angeles DREs traveled to these other States to supervise field application and certification of these student DREs. After these students had attained certification as DREs, instructor schools were held to develop some of these new DREs as instructors. Subsequent DRE schools, conducted primarily by these new instructors, were then held in these additional States. This basic format of DRE expansion through the development of an initial cadre of DREs, followed by an instructor school, has continued to this day.

In the late 1980s, it was becoming clear to U.S. law enforcement and traffic safety officials that the DEC Program was poised for tremendous growth. Undoubtedly, for the DEC Program to expand, it needed administrative support and oversight on a national level. The International Association of Chiefs of Police (IACP) had maintained an ongoing relationship with NHTSA for years. The IACP supported NHTSA training programs for law enforcement, and advised NHTSA on research needs in traffic enforcement. In 1989, the IACP assumed this oversight, and became the credentialing and regulating body for Drug Recognition Experts.

In 1988, the United States Congress passed the Omnibus Drug Bill. This legislation funded a large-scale expansion of DRE training. Due in large measure to this bill, today law enforcement agencies in all 50 States have adopted the DEC Program. As of 2015, there are approximately 7,500 certified DREs nationwide, including approximately 1500 DRE instructors.

The program is now formally titled the Drug Evaluation and Classification Program (DECP). DRE training and certification records are now maintained by each individual State DECP Coordinator and IACP. NHTSA has maintained its role in the DECP by sponsoring curriculum updates, assisting with DRE courses nationwide, and developing and issuing training materials**.**

NHTSA Report to Congress on the DEC Program

In 1996, NHTSA evaluated its support of the development of the DECP in its report to the U.S. Congress. This report concluded:

> The Drug Evaluation and Classification Program has been remarkably successful in producing meaningful results...saving lives on our nation's roads...gaining court acceptance...and showing a

steady return on investment. NHTSA's leadership role in development and implementation of the DECP produced scientific validation of the program, effective training and certification standards, and rapid expansion and institutionalization of the program. Taking into consideration the enormous cost to society of impaired driving injuries today, the economic impact of the DEC has more than compensated for the funds expended to implement and conduct the program. Added to this are the many lives that have been saved by DREs who identified medical crises in time to save the drivers. The Drug Evaluation and Classification Program has unquestionably produced profitable results that can be counted on for years to come.